



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DR FRANK A LUCKAY  
601 TEXAN TRAIL STE 201  
CORPUS CHRISTI TX 78411

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-14-0922-01

#### **MFDR Date Received**

November 20, 2013

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Please be advised that this was a Treating Physician Referral for MMI & IR. The Treating Physician, Dr. Thomas Moloney was sent a letter from Elvia Melcho, Ombudsman (copy of letter enclosed) dated July 09, 2013. This letter was advising Dr. Moloney to perform an Alternative MMI & IR as the claimant was disputing the DDE."

**Amount in Dispute:** \$650.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Texas Mutual claim **99P0000705467** is in the Texas Star Network. (Attachment) Texas Mutual reviewed its online Texas Star Network provider directory for the requestor's name and for its fax identification number, and found no evidence **DISABILITY EVALUATION CENTER** or Dr. F. Luckay, M.D., are participants in that Network."

**Response Submitted by:** Texas Mutual Insurance Company

### **SUMMARY OF FINDINGS**

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|-------------------|-------------------|------------|
| July 30, 2013    | CPT Code 99456-WP | \$650.00          | \$650.00   |

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. 28 Texas Administrative Code §126.17 sets out the guidelines for examination by a treating doctor or referral

doctor after a designated doctor examination to address issues other than certification of maximum medical improvement and the evaluation of permanent impairment.

4. 28 Texas Administrative Code §127.140 sets out procedures for disqualifying associations for designated doctors.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 19, 2013

- CAC – 38 - Services not provided or authorized by designated (Network/primary care) providers.
- 727 – Provider not approved to treat Texas Star Network Claimant. For Network information call 800-381-8067.

Explanation of benefits dated October 25, 2013

- CAC – 193 – Original payment decision is being maintained. Upon review. It was determined that his claim was processed properly.
- CAC – 38 – Services not provided or authorized by designated (Network/Primary Care) Providers.
- 724 - No additional payment after a reconsideration of services. For information call 1-800-937-6824.
- 727 – Provider not approved to treat Texas Star Network Claimant. For Network Information call 800-381-8067.

### **Issues**

1. Were the services provided in accordance with Texas Administrative Code §126.17?
2. Are the respondent's denial reason codes CAC-38 and 727 supported?
3. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
4. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

### **Findings**

1. The service provided was a designated doctor examination, performed at the request of the injured employee, on 07/30/2013. The purpose was to dispute a previous determination of Maximum Medical Improvement and Impairment Rating that was performed on 4/9/2013. Texas Administrative Code §126.17 states: (a) An examination by the injured employee's treating doctor or another doctor to whom the injured employee is referred by the treating doctor to determine any issue other than certification of maximum medical improvement and the evaluation of permanent impairment may be appropriate after a designated doctor examination if: (2) the injured employee is not satisfied with the designated doctor's opinion". A "Request for an Alternative Certification" by the injured employee was submitted by the requestor and it states in part "the injured employee disagrees with the designated doctor's opinion". The Division finds that the services were provided in accordance with Texas Administrative Code §126.17.
2. The Respondent denied the disputed services with reason code CAC-38 "Services not provided or authorized by designated (Network/Primary Care) providers" and reason code 727 "Provider not approved to treat Texas Star Network Claimant" Per Texas Administrative Code §126.17(a)(6) "A disqualifying association is any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor. Disqualifying associations may include: (6) a contract with the same workers' compensation health care network certified under Chapter 1305, Insurance Code or a contract with the same political subdivision or political subdivision health plan under Labor Code §504.053(b)(2) that is responsible for the provision of medical benefits to the injured employee". The respondent denied the disputed services in part because the health care provider was not within the designated certified network. Contrary to the respondent's denial, if the provider was within the network it would have been considered a Disqualifying Association per Texas Administrative Code §127.140(a)(6). The Division finds that the requestor's denial reasons CAC-38 and 727 are not supported.
3. Requestor billed with 99456-WP for the amount of \$650.00 for two units for a Maximum Medical Improvement (MMI) and Impairment Rating (IR) exam  
Per Administrative Code §134.204 states: (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows; (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include; (3) The following applies for billing and reimbursement of an MMI evaluation; (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350; (4) The following applies for billing and reimbursement of an

IR evaluation; (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form; (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas; (i) Musculoskeletal body areas are defined as follows; (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet); (ii) The MAR for musculoskeletal body areas shall be as follows; (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area.

Review of the submitted documentation supports a referral from the Treating Doctor to address Maximum Medical Improvement (MMI) and Impairment Rating (IR) as request from injured worker disputing previous Designated Doctor Exam (DDE). Supporting documentation supports a Maximum Medical Improvement (MMI) and Impairment Rating (IR) exam addressed with one body area performed using range of motion method.

Therefore, CPT Code 99456-WP is supported and the total MAR is \$650.00.

4. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, additional reimbursement in the amount of \$650.00 is recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

|           |  |         |
|-----------|--|---------|
| _____     | _____                                  | 1/29/14 |
| Signature | Medical Fee Dispute Resolution Officer | Date    |

## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

***Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**